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American Physical Therapy Association

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Expiring Medicare Provider Payment Policies

United States House of Representatives
Committee on Ways and Means
Subcommittee on Health

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Chairman Herger, Ranking Member Stark, and Members of the Health Subcommittee of the House Committee on Ways and Means:

On behalf of the American Physical Therapy Association (APTA) and its 82,000 members, thank you for the opportunity to provide testimony on Medicare payment policies that expire at the end of the 2011 calendar year and our perspective on a particular policy that should be extended, the exceptions process to the financial limitations on outpatient physical therapy, occupational therapy, and speech-language pathology services. These arbitrary therapy caps on rehabilitation services that beneficiaries can receive in a year adversely impact seniors and individuals with disabilities, especially those most in need of these critical services. The therapy caps are primarily a beneficiary issue that expire at the end of the year and secondarily a payment policy issue for the qualified providers of these services; physical therapists, occupational therapists and speech-language pathologists.

The therapy cap impacts a wide spectrum of patients and providers. This has resulted in an advocacy community of almost 50 patient and professional organizations whose common objective is to repeal the therapy caps once and for all. Many of these providers of therapy services or patients that receive them are also impacted by other expiring payment policies under the Medicare physician fee schedule that threaten the viability of outpatient rehabilitation for Medicare beneficiaries, including the sustainable growth rate and rural payment updates. This confluent of patient issues and provider payment policies threatens the availability and accessibility of rehabilitation services for the Medicare population.

Physical therapy services are cost-effective outpatient services under the Medicare Part B program that assist beneficiaries to restore function and independence. In 2008, therapy services served 4.5 million beneficiaries or 10.5% of the 42.7 million Part B beneficiaries. These services account for $4.76 billion in Medicare outpatient therapy or 2.6% of $183.3 billion in Part B expenditures and 1% of all Medicare Expenditures (Part A, Part B, and Part D combined). The average patient receives $884 in services over 11.2 treatment days.

Physical therapists provide critical health care services to assist beneficiaries under Medicare Part B to remain in their homes, communities and society at their highest potential functional level. An arbitrary cap on these services would shift costs as beneficiaries delay or decline needed care. A report issued in June 2010 by CMS's contractor, showed that in 2008, 15.3% of patients exceeded the physical therapy/speech language pathology cap. The exceptions process maintained access to physical therapy services for just over 640,000 individuals at a cost of $848 million dollars.

Once exceeded, if there is no exceptions process in place beneficiaries will not receive services that are medically necessary unless they seek treatment from hospital outpatient departments or pay out of pocket for their care. As a result, the cap can be expected to have a significant detrimental effect on beneficiaries needing rehabilitation services. In particular, the therapy cap has a disproportionate impact on older, more chronically ill beneficiaries from under-served areas, such as rural and urban population centers. Without this exceptions process, these patients

would have regressed in their health status and likely cost the Medicare program additional expenditures with admissions to facilities or visits to additional providers to address their health care needs.

Moving forward with cost-effective, sound policies that ensure access to services, eliminate inappropriate or fraudulent services, and guarantee quality care delivered by health care professionals qualified to deliver these services is a goal we share with this Committee. To meet this goal we have worked with CMS and members of Congress, including the bipartisan leadership on this Committee from Representative Gerlach and Becerra, to repeal the caps and replace them with an equitable alternative payment methodology for therapy services. APTA urges Congress to take timely action to pass legislation to repeal the therapy caps or to extend the exceptions process as an alternative payment policy for outpatient therapy services is developed.

Background of the Outpatient Therapy Cap

As part of the Balanced Budget Act (BBA) of 1997, Congress authorized a $1500 therapy cap on outpatient therapy services furnished in private practice settings, physician offices, skilled nursing facilities (Part B), comprehensive outpatient rehabilitation facilities, and rehabilitation agencies. Prior to the enactment of this legislation, the only setting that had been subject to an annual limitation on therapy services was the private practice physical therapist office. Congress exempted outpatient hospital settings from the therapy cap. Due to a quirk in statutory language, it was determined that two caps would exist, one on physical therapy and speech-language pathology combined and one on occupational therapy services. The therapy caps authorized in the Balanced Budget Act were designed to be a temporary measure until the Centers for Medicare and Medicaid Services (CMS) provided an alternative payment methodology for therapy services for Congress' consideration. The authorizing language from BBA also provided for inflationary growth beginning in 2002 for the financial limit. Today the therapy cap is $1870 per beneficiary per year for physical therapy and speech-language language and $1870 per beneficiary per year for occupational therapy with a clinically based exceptions process. This exceptions process to the therapy cap will expire on December 31, 2011.

The therapy caps originally went into effect on January 1, 1999, but were not enforced due to limitations in implementing them at the agency and local contractor level. On November 19, 1999, Congress passed the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, which placed a two-year moratorium on the $1,500 cap for 2000 and 2001. Congress passed legislation again in 2000 as part of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) to extend the moratorium on the therapy caps through 2002. In 2003, CMS delayed enforcement of the therapy cap from January 1, 2003, through September 1, 2003. The therapy cap was in place from September 1, 2003 until Congress passed the Medicare Modernization Act that extended the moratorium on the therapy cap from passage on December 8, 2003, through December 31, 2005. In the first six years of the therapy cap, Congress passed moratoriums on this policy three times and the caps were in effect for just under 100 days.

The therapy caps again went into effect temporarily on January 1, 2006, but were quickly addressed in the Deficit Reduction Act passed by Congress on February 1, 2006 by extending the exceptions process to the therapy cap. Originally, CMS implemented a two-tier approach of an automatic exceptions process for certain diagnoses likely to exceed the therapy cap and a manual process for clinicians to provide justification of medically necessary care above the arbitrary financial limitation of the therapy cap. This was modified and now allows for the use of a code based modifier to signify that therapy services above the financial limit are medically necessary and appropriate.

Congress has supported this reform to the therapy cap by providing an extension to the exceptions process five times since 2005, through the passage of the Tax Relief and Health Care Act of 2006, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act, Medicare Improvement for Patients and Providers (MIPPA) (PL 110-275), the Patient Protection and Affordable Care Act (PL 111-148), and the Medicare and Medicaid Extenders Act of 2010. The current extension of the therapy cap exceptions process expires on December 31, 2011.

The Impact:

For the Medicare beneficiaries who exceed the cap the result is detrimental and potentially devastating. The therapy cap has a detrimental impact due to several factors. First, the therapy cap is a per year per beneficiary limit. For a patient with multiple chronic conditions and it has been estimated that almost 70% of Medicare beneficiaries have more than one chronic condition, physical therapy is critical to preserving function and regaining function following an impairment. To exhaust the cap for physical therapy to treat a knee impairment only to have no therapy benefit left to treat another condition, such as a cardiac condition that results in deconditioning is short-sighted and limits gain invested in the first physical therapy treatment plan.

Second, the combined cap of physical therapy and speech-language pathology is problematic as these are distinct clinical services that occur at different times in the continuum of care and address related but separate areas of impairment. A patient with a stroke might receive extensive physical therapy to regain mobility but then see the cap limit their ability to obtain services to improve swallowing or the ability to communicate. This example of giving the patient a choice between walking and talking is an oft-cited example of the complicating factors and poor policy of the therapy cap.

And finally, services under Medicare are required to be medically necessary and providers, such as physical therapists, must meet the required regulations to demonstrate this requirement. The therapy cap places an arbitrary stopping point to therapy regardless of the necessity of the services. A patient has demonstrated need for care and we have a policy that over-rides that need. Beginning physical therapy care with the knowledge that you will be limited in your abilities to meet the patient's need due to the therapy cap places clinicians in a difficult and challenging position.

Congress has long known that allowing the therapy caps to go into effect would have a profound impact on patient care. The pattern of yearly extensions without an exit plan is not in the best interest of patients, physical therapists or the Medicare program. APTA believes the therapy cap exceptions process must be extended in 2011 and furthermore believes that reform to the payment system and benefit is needed for the long-term fiscal health of the program and to meet growing needs for cost-effective rehabilitation services under Medicare.

The Solution:

APTA believes a strong Medicare Part B program is essential to provide cost-effective, accessible and high quality health care to our nation's seniors and individuals with disabilities. The policies established under the Medicare program dramatically impact payment policies established by private payers, Medicaid, workers compensation, and others payers. The opportunity to address these fundamental policy problems under Medicare Part B is vital to move toward a sustainable delivery system that is supported by sound payment policies.

The original legislative language authorizing the therapy caps called for an alternative payment methodology to replace the caps. Without significant development in this alternative, APTA proposes that Congress extend a limited exceptions process for 2012, 2013, and 2014 and instruct the CMS to develop a per visit payment system for outpatient therapy services that controls the growth of therapy utilization for implementation by January 1, 2015. APTA has begun work on a reformed payment system for outpatient physical therapy services that we believe will strike the balance of ensuring access to services while improving payment accuracy for therapy services under Medicare Part B.

APTA would support efforts by Congress to refine the exceptions process. We encourage Congress and this Committee to work with CMS to identify ways to implement an exceptions process that ensures that patients needing services beyond the therapy cap receive those services, minimizes the administrative burden on CMS and providers, while reducing the cost of extending the therapy cap exceptions process. Limiting the exceptions process is only meant to provide temporary reductions in spending while providing a bridge to the long-term solution. APTA is working with stakeholders in the community on legislative language to meet this aim.

In addition, Congress should include language instructing CMS to develop and adopt a reformed payment system for therapy services. APTA is working on a per visit payment system that we believe will enhance the accuracy of payment for physical therapy services and prevent inappropriate billing of therapy services by non-qualified individuals. This will involve the development of a new coding structure and values for physical therapy services through the American Medical Association's (AMA) Current Procedural Terminology (CPT) Editorial Panel and AMA's Specialty Society Relative Value Scale Update Committee (RUC). This would allow for the reformed payment system to be presented to CMS for consideration in time for publication in the CY 2015 Medicare Physician Fee Schedule Rule and for implementation on January 1, 2015.

The reformed payment system APTA is developing would be per session codes based on the severity of the patient and the intensity of therapist clinical judgment and work involved in the provision of the therapy service. The physical therapy evaluation would be tiered to provide a prediction of the episode and estimated rehabilitation potential through assessment of patient severity and the intensity of services needed to meet the patient's rehabilitation goals. In addition to the evaluation process, the per session payment system would classify each patient encounter by associating it to one of three levels of patient severity that could be documented and reported on a claim form. These could include: low clinical presentation/severity; moderate clinical presentation/severity; and high clinical presentation/severity. These encounters would also be associated with an intervention level that would be characterized as low, moderate, and high. Together the evaluation and then per-visit examination and intervention system would provide a payment system that accurately reflects the professional clinical judgment of the therapist and provides the payers of these services with more meaningful ways to assess the appropriateness of these services.

We believe, and there is evidence to support, that the severity of the patient is impacted by the medical condition of the patient, the physical impairments resulting from these conditions(s), the patient's ability to function, and their ability to participate in activities of daily living. These factors, taken together, underlie the provider's judgment about the "severity" level (minimal, moderate, and significant) of the patient's condition. For example, two individuals with a diagnosis of stroke could differ significantly in severity level based on the number and impact of resulting impairments, the inability to perform functional tasks and activities, and their ability to participate in activities related to their societal roles. It is incumbent upon the therapist to make a clinical judgment based on their significant expertise regarding the impact of these factors on the patient and the plan of care. The intervention level involves a series of judgments that the therapists must make regarding the particular combination of interventions to implement, how much of each technique to provide during each patient encounter, and the optimal duration of the care.

APTA believes the use of per-session payment could result in more appropriate valuation of therapy services and permit clinicians more flexibility in determining intervention approaches to reach the patient's rehabilitation goals. Per-session payments that reflect average per-session costs based upon the severity of the patient's condition and complexity of the services required, would eliminate overpayment for individual services provided while leaving the therapist in control of treatment decisions. These factors could lead to more predictable and reduced therapy expenditures.

This approach would ensure compliance with other areas of payment policy under the Medicare rehabilitation benefit, such as delivering care that is medically necessary and driven by the development of an appropriate functional goal-based plan of care. We also believe this will be congruent with and advance efforts in quality reporting, health information technology and the standardization of practice patterns through assessment tools and registries. Although this system needs refinements and further development to ensure appropriate safeguards, APTA believes it is far superior to the current time-based procedural system that value volume over

outcomes. This reformed payment system has the potential to not only improve payment accuracy and better reflect quality care, but provide long-term cost savings through greater efficiency and accuracy in billing. This new payment policy couples with needed reforms to reduce fraud and abuse, such as the elimination of the in-office ancillary services exception to the federal self-referral ban (also known as Stark law) that has recently been studied by the Medicare Payment Advisory Commission (MedPAC) would be an example of potential reforms to the therapy benefit to reduce unwarranted spending.

Providing Savings under Medicare to Pay for the Cost of These Policy Proposals

APTA would highlight the following three cost saving proposals for consideration to provide savings to pay for the cost of these policy proposals to address the therapy cap and payment reform under Medicare Part B:

Strengthen Medicare Program Integrity Efforts
Legislative proposals to intensify program integrity efforts include penalizing providers who do not update their enrollment records, validating physician orders prior to payment for certain high-risk services, and requiring prepayment review for all power wheelchairs. These program integrity proposals were included in the President's FY 2012 Budget and have also been identified by members of the House Majority for debt ceiling/deficit reduction options. The Congressional Budget Office estimates the potential savings of this proposal at $700 million over 10 years.

Recover Erroneous Payments Made to Insurers Participating in Medicare Advantage
Under current law, CMS is required to risk adjust payments to Medicare Advantage (MA) plans to reflect variation in health risk, and thus cost, of different beneficiaries. In 2008, CMS announced a pilot program to audit a sample of plans' records to validate the accuracy of the adjusted payments. Under this pilot program, CMS evaluates the medical records of beneficiaries (validation audits). The President's FY 2011 and FY 2012 budgets included a policy that would require CMS to extrapolate the error rate found in the risk adjustment validation audits to the entire Medicare Advantage plan payment for a given year. This policy option would ensure that Medicare is accurately paying Medicare Advantage plans by identifying – and correcting – both overpayments and underpayments. The Congressional Budget Office estimates the cost savings of this proposal to be $2.6 billion over 10 years.

Medicare Improvement Fund
The Medicare Improvement Fund (MIF) has been used in recent years as a venue to "store" excess Medicare savings so that they could be used in the future to pay for needed Medicare policy (e.g., SGR patches, Medicare extenders, etc). Under current law, the Recovery Act created penalties for Medicare providers that have failed to adopt and meaningfully use electronic health records by 2015. In 2019 and beyond, those penalties are put into the MIF. This proposal would remove them from the MIF to make them available for deficit reduction or to offset other spending in the package. The Congressional Budget Office estimate of cost savings from this proposal is $900 million over 10 years.

In closing, APTA stands ready to work with the Committee to reform both the current therapy benefit under Medicare Part B, to ensure that therapy services are only provided to beneficiaries by qualified providers of these services, and to reform the payment system to meet the original language of the Balanced Budget Act that authorized this temporary therapy cap. We believe a reformed payment system and cleaning up of the benefit to ensure the integrity of the services are the only way to ensure beneficiary access and to have an adequate payment system to sustain a qualified provider community to serve these beneficiaries in a high-quality, cost-effective fashion. We commend the Committee for this hearing of expiring Medicare policies and encourage an extension of the therapy cap exceptions process.